

Midway Family Dental Patient Registration

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE: _____

PATIENT NAME: _____

HOME PHONE: _____

ADDRESS: _____

BUSINESS PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

CELL/PAGER: _____

DOB: _____ AGE: _____ MALE: _____ FEMALE _____

E-MAIL ADDRESS: _____

MARRIED: _____ SINGLE: _____ DIVORCED: _____ WIDOWED: _____

SOCIAL SECURITY #: _____

INSURANCE CO: _____

STUDENT STATUS: _____ SCHOOL: _____

EMPLOYER: _____

EMPLOYEE: _____

YOUR EMPLOYER: _____

EMPLOYEE DOB: _____

OCCUPATION: _____

SOCIAL SECURITY NO: _____

BUSINESS ADDRESS: _____

****SECONDARY COVERAGE? PLEASE LET US KNOW.**

CITY: _____ STATE: _____ ZIP _____

RESPONSIBLE PARTY: _____

RELATIONSHIP TO PATIENT: _____

SPOUSE: _____

ADDRESS: _____

SPOUSE'S EMPLOYER: _____

CITY: _____ STATE: _____ ZIP: _____

OCCUPATION: _____

PHONE NO: _____

BUSINESS ADDRESS: _____

EMERGENCY CONTACT:

CITY: _____ STATE: _____ ZIP: _____

NAME: _____ PHONE NO: _____

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: _____

RELATIONSHIP: _____

WHOM MAY WE THANK FOR REFERRING YOU?

NAME: _____

CONSENT: The information contained on this form is TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

FINANCIAL: The responsibility for payment of dental services provided in this office for myself and/or my dependents is mine, due and payable at the time of services are rendered unless prior financial arrangements have been made.

CANCELLATION POLICY: We reserve the right to charge for appointments cancelled with 24 hours notice. Arriving more than 30 minutes late for an appointment without calling is considered a missed appointment.

INSURANCE: I hereby authorize Midway Family Dental to release to my insurance company, information acquired in the course of my dental care and hereby authorize benefits to be paid directly to Rollin B Jackson III, DMD. I understand the estimated co-payment is not a guarantee of insurance benefits, and I am responsible for any unpaid balance.

SIGNATURE OF RESPONSIBLE PARTY: _____ **DATE:** _____